SUFFOLK COUNTY DEPARTMENT OF HEALTH SERVICES
BUREAU OF SERVICES FOR CHILDREN WITH DISABILITIES

REQUEST FOR IFSP REVIEW

To be sent to the EIOD

DATE OF REQUEST:_____/_____/_____ **EIOD:**_____

NAME OF CHILD:_____ **DOB:**_____/_____/_____

EFFECTIVE IFSP DATES:_____/_____/_____ **TO** _____/_____/_____

PROVIDER ASSISTING IN PREPARING REQUEST:_____

PROVIDER'S DOMAIN:_____ **AGENCY AFFILIATION:**_____

REASON FOR REVIEW (Attach all supporting documentation.):

I, _____, **request this IFSP review. Date:**_____/_____/_____

Parent/Guardian Signature

For EIOD Use Only:

DATE RECEIVED:_____/_____/_____

COMMENT(S):